IN THE

Supreme Court of the United States

OCTOBER TERM, 1978

Nos. 78-329, 78-330

FRANCIS X. BELLOTTI, Attorney General of the Commonwealth of Massachusetts, *et al.*,

Appellants,

JANE HUNERWADEL,

Appellant,

—v.—

WILLIAM BAIRD, *et al.*,

Appellees,

PLANNED PARENTHOOD LEAGUE OF MASSACHUSETTS, CRITTENTON HASTINGS HOUSE & CLINIC and PHILLIP G. STUBBLEFIELD, M.D.,

Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MASSACHUSETTS

MOTION FOR LEAVE TO FILE BRIEF OF *AMICI CURIAE* AND ANNEXED BRIEF OF THE PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., THE YWCA NATIONAL BOARD, THE NATIONAL FAMILY PLANNING FORUM, INC., THE AMERICAN ACADEMY OF CHILD PSYCHIATRY, THE SOCIETY FOR ADOLESCENT MEDICINE, THE ASSOCIATION OF PLANNED PARENTHOOD PHYSICIANS, THE AMERICAN PUBLIC HEALTH ASSOCIATION AND CERTAIN MEDICAL SCHOOL DEANS, PROFESSORS AND INDIVIDUAL PHYSICIANS

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The undersigned, as counsel for the Planned Parenthood Federation of America, Inc., the YWCA National Board, the National Family Planning Forum, Inc., the American Academy of Child Psychiatry, the Society for Adolescent Medicine, the Association of Planned Parenthood Physicians, the American Public Health Association and 59 medical school deans, professors and individual physicians respectfully move this Court for leave to file the accompanying brief *amici curiae*.

Planned Parenthood Federation of America, Inc.

Planned Parenthood Federation of America, Inc., also known as Planned Parenthood-World Population (Planned Parenthood), is a not-for-profit corporation organized in 1922 and existing under the laws of the State of New York. Its headquarters are in New York City. It is the leading national voluntary public health organization in the field of family planning.

Planned Parenthood has 189 affiliates in 43 states and the District of Columbia, all of them separate not-for-profit entities. These affiliates operate approximately 725 family planning clinics offering services to the public. Most affiliates offer medical services including 31 which offer abortion services as part of their program. Nine affiliates, including the Planned Parenthood League of Massachusetts, one of the Appellees herein, are educational units without medical services. Most Planned Parenthood affiliates which do not perform abortions themselves offer pregnancy counseling and referral.

Planned Parenthood provides its affiliates with guidance in the areas of contraception, voluntary sterilization, infertility, abortion, sex education and education for marriage and parenthood. Each of the affiliates offering medical services functions under strict medical standards promulgated by the National Medical Committee in conjunction with local medical advisory committees. These committees are made up of health professionals, the large majority of whom are physicians.

Planned Parenthood also functions as a clearing house for information and services relating to these same areas. It formulates medical and clinical standards which are available to its affiliates and generally on a nationwide basis and develops guidelines and materials relating to public and professional education in all aspects of family planning. Its Medical Director and other consultants confer with other national medical organizations, medical school faculties and local agencies in relation to teaching techniques, formation of clinics and the like.

Many of Planned Parenthood's affiliates operate in cooperation with local public health facilities. The affiliates are also teaching and training centers for physicians, nurses, teachers and social workers from this country and foreign countries and provide referral services for their clients to qualified medical specialists and facilities.

Planned Parenthood is committed to the principle that safe abortions should be available to all who seek them as a necessary corollary of Planned Parenthood's activities in the area of contraception. While Planned Parenthood does not view abortion as an alternative to contraception, it recognizes that abortion services are essential to protect women where contraception is unavailable, where it has not been used for some other reason and where it has failed.

Planned Parenthood's Medical Standards and Guidelines contain requirements for adequate pregnancy and abortion counseling which include standards for the qualifications

and training of counseling personnel. These Standards and Guidelines provide: "If patient consents, efforts should be made to involve significant members from the women's environment in the counseling process—i.e., boyfriend, husband, parents or others who may lend support." Planned Parenthood Manual of Medical Standards and Guidelines, Part One, Section VII-C (revised July 31, 1978). However, consent for the abortion must be required only of the woman who chooses the procedure. Manual of Medical Standards and Guidelines, Part One, Section VII-A (December 15, 1977).

YWCA National Board

The YWCA, a not-for-profit corporation, is the oldest and largest multiracial, multicultural women's membership organization in the world. It has a Christian purpose which involves women of diverse backgrounds and faiths in the struggle for peace, dignity, freedom and justice for all people.

The National Planning Forum, Inc.

The National Family Planning Forum is a private not-for-profit corporation composed of more than 400 agencies, organizations and consumer members. The members represent every type of family planning agency, including State and City Departments of Health, hospitals, free-standing clinics, non-profit Councils and reproductive health clinics. The membership includes broad representation from both urban and rural programs.

The primary mission of the National Family Planning Forum is to improve the delivery and availability of family planning services in the United States. The Forum was incorporated in 1974 but has existed as a national organization since 1970. It has played a major leadership role in the development of high quality family planning services in the United States.

American Academy of Child Psychiatry

The American Academy of Child Psychiatry is a professional association of 2,000 child psychiatrists. It was founded in 1952 and is concerned with advancing child and adolescent mental health.

Society for Adolescent Medicine

The Society for Adolescent Medicine is a national organization of health care providers to the adolescent age population. It consists of 800 members all of whom are physicians and health professionals.

Association of Planned Parenthood Physicians, Inc.

Planned Parenthood works closely with the Association of Planned Parenthood Physicians, Inc. (APPP), a New York not-for-profit corporation organized in 1974. APPP is the successor to the American Association of Planned Parenthood Physicians, an unincorporated association which was organized in 1963. In 1978, APPP had 850 members, all of whom were physicians or other health professionals associated with family planning.

APPP was formed for scientific, educational and charitable purposes and specifically to promote the ongoing interest in family planning in order to improve the stability and health of the family through responsible parenthood.

American Public Health Association

The American Public Health Association is a national non-governmental organization established in 1872. Its

object is to protect and promote personal and environmental health. With a membership of over 50,000, it is the largest public health organization in the world. Within this membership, both professional health workers and consumers act in a leadership role to develop a national policy to provide equitable, quality health care for all citizens.

Medical School Deans, Professors and Individual Physicians

The 59 individual physicians who as *amici* subscribe to this brief all practice obstetrics and gynecology as their medical specialty or are responsible for the education of medical students and residents, some of whom are in training in the specialty of obstetrics and gynecology.

Concerns of the *Amici*

Amici have a longstanding concern with the problem of teenage sexual activity and the attendant risk of teenage pregnancy which involves more than half the adolescent population. *11 Million Teenagers* (Alan Guttmacher Institute 1976); Klein, "Antecedents of Teenage Pregnancy," 21 Clinical Obstetrics & Gynecology, No. 4, pp. 1151-1159 (Harper & Row Medical Dep't 1978). Over 40% of the women in the United States aged 15-19 years in 1976 had experienced pre-marital intercourse; over a million teenagers experienced a pregnancy, of which an estimated 780,000 were premarital. Zelnik and Kantner, "Contraceptive Patterns and Premarital Pregnancy among Women Aged 15-19 in 1976," 10 Family Planning Perspectives 135 (1978). Over 570,000 live births to women under 20 were registered in 1976. In the same year, many other teenagers suffered miscarriages and over 300,000 obtained abortions, accounting for approximately one-third of all abortions

obtained. Tietze, "Teenage Pregnancies: Looking Ahead to 1984," 10 Family Planning Perspectives 205 (1978).

Births to adolescent mothers often have crippling health, psychological, economic and educational consequences for mother and child. *Amici* believe that the Massachusetts statute which the United States District Court declared unconstitutional in this case would, if that judgment were reversed by this Court, prevent many teenaged women from obtaining abortions that they want and need. By mandating parental consent or notification in all cases, the statute would, moreover, cause other teenaged women to postpone the termination of their pregnancies to a later stage when the health hazards of abortion are far greater. *Amici* agree that pregnant minors should consult their parents, but because some minors will in no circumstances do so and because for others, parents may not be the best source of counseling, *amici* believe that the Massachusetts statute unconstitutionally interferes with the right of physicians to administer necessary health care in accordance with their best professional judgment and the right of adolescent women to receive such health care.

Planned Parenthood, the National Family Planning Forum, Inc., the National Board of the YWCA, the American Academy of Child Psychiatry, the Society for Adolescent Medicine, APPP, the American Public Health Association and the individual medical school deans, professors and physicians named above, by reason of their long experience and knowledge of the health needs of adolescents believe that they are in a unique position to aid the Court in its resolution of the issues raised in this case. *Amici* have assembled relevant and recent scientific findings which are discussed herein.

Consent of Parties to Filing of Brief

Amici have sought the consent of the parties to file this brief. Counsel for the Appellees have consented. Counsel for the Appellants has consented to the filing of an *amicus* brief by the American Public Health Association but not by the Planned Parenthood Federation of America, Inc. or the Association of Planned Parenthood Physicians.

Respectfully submitted,

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This brief is submitted by the above named *amici curiae* conditionally upon the granting of the motion for leave to file to which it is attached.

Interest of the *Amici*

The interest of the *amici* is set forth in the attached motion for leave to file.

Statutory Provisions Involved

The issue in this case is the constitutionality of Massachusetts General Laws ch. 112, §12 S which defines procedures that must be followed before an unmarried minor can obtain an abortion, as follows:

> If the mother is less than eighteen years of age and has not married, the consent of both the mother and her parents is required. If one or both of the mother's parents refuse such consent, consent may be obtained by order of a judge of the superior court for good cause shown, after such hearing as he deems necessary. Such a hearing will not require the appointment of a guardian for the mother.
>
> If one of the parents has died or has deserted his or her family, consent by the remaining parent is sufficient. If both parents have died or have deserted their family, consent of the mother's guardian or other person having duties similar to a guardian, or any person who had assumed the care and custody of the mother is sufficient.
>
> The commissioner of public health shall prescribe a written form for such consent. Such form shall be signed by the proper person or persons and given to

> the physician performing the abortion who shall maintain it in his permanent files.
>
> Nothing in this section shall be construed as abolishing or limiting any common law rights of any other person or persons relative to consent for the performance of an abortion for purposes of any civil action or any injunctive relief under section twelve U.

This statute comes before this Court for the second time. In *Bellotti* v. *Baird*, this Court remanded the above statute for construction by the Massachusetts courts, stating:

> "The picture thus painted by the respective appellants is of a statute that prefers parental consultation and consent, but that permits a mature minor capable of giving informed consent to obtain, without undue burden, an order permitting the abortion without parental consultation, and, further, permits even a minor incapable of giving informed consent to obtain an order without parental consultation where there is a showing that the abortion would be in her best interests. The statute, as thus read, would be fundamentally different from a statute that creates a 'parental veto.'" 428 U.S. 132 at 145 (1976).

In its prior opinion dealing with this statute, this Court warned that it would not uphold a statute that "impose(s) undue burdens on a minor capable of giving an informed consent" or that "creates some unanticipated interference with the doctor-patient relationship." 428 U.S. at 147-148.

The United States District Court for the District of Massachusetts, to which the case was thus remanded, certified nine questions to the Massachusetts Supreme Judicial Court. That court, in answer to the questions certified, construed the Massachusetts statute in an extremely re-

strictive way, in stark and dramatic contrast to "the picture painted by the respective appellants," i.e. the representatives of the State of Massachusetts, when the case was previously argued in this Court.

The Massachusetts Attorney General originally represented the statute as one that, in the words of this Court, "prefers parental consultation and consent, but that permits a mature minor capable of giving informed consent to obtain, without undue burden, an order permitting the abortion without parental consultation. . . ." However, under the statute as it has now been construed by the Massachusetts Supreme Judicial Court, "parental consultation is required in every instance where an unmarried minor seeks a nonemergency abortion" except where the minor's parents (or their equivalent) are unavailable. *Baird* v. *Attorney General*, Mass. Adv. Sh. (1977) 96, 360 N.E. 2d 288 at 303.

Although the clear implication of this Court's language, quoted above, was that the mature minor need establish only the fact of her maturity in order to be able to give effective consent for an abortion, as construed by the Massachusetts Supreme Judicial Court, if one or both parents refuse consent, a judge of the Superior Court may authorize an abortion only after making a finding "on the basis of all relevant views presented to him . . . (I)n circumstances where he determines that the best interests of the minor will not be served by an abortion, the judge's determination should prevail . . ." 360 N.E. 2d at 293.

Despite this Court's plain suggestion that any requirement that would "impose undue burdens on a minor capable of giving an informed consent" was constitutionally defective, the Massachusetts Supreme Judicial Court has held

that the statute mandates for all minors, including all mature minors, a court proceeding in which the minor in effect must sue her own parents as named defendants if she wishes to terminate an unwanted pregnancy against their wishes. The state court has ruled out the judicial proceeding "without parental consultation" which this Court contemplated not only for mature minors but also for immature minors "where there is a showing that the abortion would be in [their] best interests." 428 U.S. at 145.

SUMMARY OF ARGUMENT

Amici in their various capacities have had extensive experience in connection with the treatment of the health needs of adolescents. The Massachusetts law as interpreted by the Massachusetts Supreme Judicial Court places undue burdens on a minor seeking to terminate an unwanted pregnancy. This belief is based on the following grounds: 1) The Massachusetts statute's requirement of parental consent or notification in all cases creates a *de facto* parental veto which must fall under this Court's decision in *Planned Parenthood of Central Missouri* v. *Danforth*, 428 U.S. 52 (1976).

2) While *amici* agree that pregnant minors should consult their parents, the medical literature as well as the evidence in this case establishes that some minors will in no circumstances do so and that for many minors parents may not be the best source of counseling.

3) *Amici* will show that in those cases where a minor does attempt to comply with the Massachusetts statute, the mandated procedure will inevitably postpone the termination of many pregnancies, thereby substantially increasing

the health hazards to the pregnant minor if she does succeed in having a legal abortion.

4) The Massachusetts statute denies the equal protection of the laws to those minors who choose to terminate their pregnancies as opposed to those minors who choose to carry their pregnancies to term.

ARGUMENT

POINT I

The Massachusetts statute's requirement of parental involvement in all cases creates an unconstitutional *de facto* veto on minors' abortions in violation of the Due Process Clause of the 14th Amendment to the United States Constitution.

In *Planned Parenthood of Central Missouri* v. *Danforth*, this Court held that a state may not "impose a blanket provision . . . requiring the consent of a parent or person *in loco parentis* as a condition for abortion of an unmarried minor during the first 12 weeks of her pregnancy." Although recognizing that "the state has somewhat broader authority to regulate the activity of children than of adults", this Court nevertheless held that the interest advanced by the state in safeguarding the family unit and parental authority must yield to "the right of privacy of the competent minor . . ." This Court ruled that a state does not have the constitutional authority "to give a third party an absolute, and possibly arbitrary, veto over the decision of the physician and his patient to terminate the patient's pregnancy". 428 U.S. 52 at 74 (1976).

Unwanted teenage pregnancy is a distressingly common problem. A recent comprehensive study of the Department of Health, Education and Welfare (DHEW) Office of Child Health Affairs concluded "Teenage pregnancy . . . is one of the most if not the most pressing health problem of individuals nineteen years of age and under." *Teenage Pregnancy,* 1976, p. 1. Another recent comprehensive study of adolescent health states that it is the consensus of medical experts that teenagers are "biologically at risk in childbearing." DHEW, *Approaches to Adolescent Health Care,* 1975, at p. 17. Yet another high level DHEW study summarized the problems of teenage pregnancy as follows:*

Adolescents are at high risk of pregnancy

- More than four million adolescent females (ages 15-19) have had sexual intercourse—only 2 million use contraceptives. Seven million adolescent males are sexually active.
- Thirty-seven percent of unmarried adolescents (15-19), when interviewed, reported that they did not use any contraceptive method the last time they had sexual intercourse.
- One million adolescents become pregnant annually (one in ten adolescent females); almost 600,000 give birth.
- Nearly 250,000 births (400,000 pregnancies) are to adolescents 17 and under; 130,000 births (30,000 pregnancies) are to adolescents under 15.

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* The Report (hereinafter *Schuck Report*) was the work of a task force of 50 knowledgeable Assistant Secretaries and the General Counsel of DHEW. The group solicited the opinions of many and diverse outside persons who participated in the committee's deliberations through submitting written comments and/or attending two days of public meetings.

Initiative to Address Adolescent Pregnancy and Related Issues —DECISION MEMORANDUM, DHEW 1977, pp. 1-2.

- Adolescent birth rates are declining, but more slowly than the rates for older women.

Adolescents receive one-third of all abortions in the United States

- Approximately 300,000 adolescents receive abortions annually; almost half are to those 17 and under.
- Adolescents are over-represented among women receiving second trimester abortions, which pose greater health risks.

Pregnancy during adolescence poses serious health risks for mother and child

- Complications of pregnancy and childbirth are 9-30 percent higher for those under 15 than for women aged 20-24.
- Compared to women 20-24, the incidence of low-birth weight is twice as high for infants of mothers under 15, and 30 percent higher for infants of mothers aged 15-19. Low-birth weight infants run higher risk of death and serious developmental defects.
- Repeated pregnancy during adolescence increases risks to adolescent mothers and their children.

Pregnancy during adolescence raises serious social and economic risks

- Surveys indicate that between one-third and one-half of all adolescent females who drop out of school do so because of pregnancy or marriage. Early parenthood is a major reason for males to drop out of school.

- Adolescent parents run higher risks of unemployment and welfare dependence than those who delay their first child until their twenties.
- One-third of all births to adolescents are out-of-wedlock, one-half of all out-of-wedlock births in the United States.
- Adolescents who marry are 2-3 times more likely to divorce than those who marry in their early twenties.

The adolescent with an unwanted pregnancy is in an extremely difficult and emotionally charged situation which subjects her to constant social, psychological and physiological tension. Regardless of her attitude toward teenage sexual activity, the adolescent woman is usually upset by the fact of her pregnancy and the possibility of parenthood. Shouse, "Psychological and Emotional Problems of Pregnancy in Adolescence", in Zackler and Brandtadt, eds., *The Teenage Pregnant Girl* (Thomas, 1975), pp. 161-168; Martin, "Psychological Problems of Abortion for the Unwed Teenage Girl", 88 Genetic Psychology Monographs 23 (1973). She needs patient, effective counseling, but feels reluctant to approach anyone with what she may perceive to be a shameful, embarrassing or intensely personal problem. She may in fact even attempt to deny the fact of her pregnancy and consequently postpone her efforts to seek guidance, or, more important, medical aid. Baudry and Wiener, "The Pregnant Patient in Conflict About Abortion: A Challenge for the Obstetrician", 119 Am. J. Obst. & Gyn. 705 (1974).

As interpreted by the state court, the Massachusetts statute obligates all minors to seek parental consent and gives them the right to go to court only if they have not been able to obtain the consent of both parents, thereby man-

dating parental notification in every case. Although a requirement of parental involvement will have little impact in those family situations where parents and their children share open and relaxed attitudes on the issue of teenage sexual activity and abortion, where the home environment is indifferent or openly hostile to the minor and/or her pregnancy, the statute as so construed will compel a confrontation at home and in court between bitterly irreconcilable parties.

It is well known that parents exercise great influence over the sexual patterns of their children and that parents who are not supportive of teenage sexual activity or who cannot accept abortion as a method of terminating an unwanted pregnancy react to their daughter's condition in despair, disappointment and even bitterness. Furstenberg, *Unplanned Parenthood: The Social Consequences of Teenage Childbearing* (Free Press 1976). In such circumstances, to compel a young woman to attempt to obtain the consent of parents who are non-supportive or hostile to her own interests or needs will only further traumatize a person already upset by her pregnancy. As one study noted of such minors:

> "Half of them could not bring themselves to tell their parents of their pregnancy for several months; in a quarter of the families, four or more months passed before the pregnancy was disclosed. More often than not, the adolescents never actually told their parents; the mothers learned about it through a third party or detected it on their own. Only 3% of the women said their mothers were pleased, and half recalled that they were angry." Furstenberg, *supra*, p. 55.

A recent study has found:

> "Although a small number of prospective grandparents accept the pregnancy easily, most do not. Initially anger appears to be the most common parental response. This anger may be strong enough that the daughter feels the necessity to leave her home. Accompanying the anger there is often a strong sense of shame and guilt, shame about what neighbors and friends will say and about failed aspirations for the family and offspring, and guilt about what went wrong and what role the parents may have played in inadvertently contributing to the conception". Osofsky & Osofsky, "Teenage Pregnancy: Psychosocial Considerations" in 21 Clinical Obstetrics & Gynecology, No. 4, pp. 1164-1165 (Harper & Row Medical Dep't, December 1978).

Many teenagers, for various reasons, feel that they cannot confide in their parents about their sexual and contraceptive behavior. Recent studies indicate that requiring parental notification will not have the effect of discouraging sexual activity among teenagers or even of increasing substantially the proportion who already willingly tell their parents about their clinic attendance. Instead, any requirement of parental notification with respect to contraception will cause a substantial number of young people who are now protected against unwanted pregnancies to avoid consulting responsible physicians and clinics, and will thereby result in increasing the proportion of unwanted and out-of-wedlock births occurring among the adolescent population. Torres, "Does Your Mother Know . . . ?" 10 Family Planning Perspectives 280 (1978); Tietze, "Teenage Pregnancies: Looking Ahead to 1984," 10 Family Planning Perspectives 205 (1978); Pearson, "Social and

Psychological Aspects of Extra-Marital First Conceptions," 5 J. Biosoc. Sci. 453 (1973). The same kind of refusal to seek effective and reputable help has even more dire consequences with respect to the already pregnant young woman.

Some pregnant minors may not wish to inform their parents of their condition out of a genuine desire not to upset them. An appreciable number of minors may fear the prospect of openly hostile or violent parental reactions. One father, upon learning of his daughter's pregnancy said:

> "I didn't know whether I could have killed her or just died myself . . . I could have killed him". Furstenberg, *supra*, p. 55.

The record in this very case offers additional proof of the detrimental impact a requirement of parental notification or consent may have on the interests of the minor. Mary Moe explained that she wished to avoid parental involvement because she feared the physical harm her father might inflict on her and her boyfriend. See also for examples of other apprehensions of harm *In re Diane*, 318 A. 2d 629 (Del. 1974), and *In re Smith*, 16 Md. App. 209, 295 A. 2d 238 (1972).

The Massachusetts statute as construed by the Supreme Judicial Court of Massachusetts presents an alarming prospect to a minor who finds herself forced into the ordeal of confronting unsupportive parents. The defendants' own expert, Dr. Sprague Hazard, testified that, in those situations where a minor's parents are unalterably opposed to an abortion, a court proceeding might cause severe psychological trauma. 2 App. 422.

Faced with such a statutory scheme, a minor may resort to running away, attempting suicide or even trying to

abort herself. Semmens and Lamers, *Teenage Pregnancy* (Thomas, 1968), pp. 14-21. She may also try to obtain an illegal abortion, perhaps from an unlicensed practitioner, despite the fact that such abortions present increased risks of major complications and death. See Kahan *et al.*, "The Effect of Legalized Abortion on Morbidity Resulting From Criminal Abortion", 121 Am. J. Obst. & Gyn. 114 (1975).

A 1972 study of suicide attempters admitted to Los Angeles County, University of Southern California Medical Center found that 75% of suicide attempters are female, their average age sixteen. Teicher, "A Solution to the Chronic Problem of Living: *Adolescent Attempted Suicide*" in Current Issues in Adolescent Psychiatry (Brunner-Mazel 1973), p. 131. After interviewing all of these teenagers Dr. Teicher found 22% of the girls were pregnant or believed themselves to be pregnant when they attempted suicide. In contrast, *none* of the girls in a control group of teenagers who did not attempt suicide during that period were or believed themselves to be pregnant. *Ibid.* at 136. Dr. Teicher's study identified unplanned pregnancy as a primary cause of suicide attempts among young women.

Moreover, where, as here, the appointment of counsel for the child is discretionary, a substantial constitutional issue is raised regarding the fairness of the proceedings. One court recognized the minor's clearly disadvantaged position in cases where she does not have her own counsel and the court chooses not to assign counsel to her. "Certainly she cannot be expected to litigate a question as emotionally charged as that contemplated by the statute—child vs. parent—without the guiding hand of counsel", *Wynn* v. *Scott*, 448 F. Supp. 997, 1004 (N.D. Ill. 1978), *aff'd Wynn* v. *Carey*, No. 78-1262 (7th Cir. August 17, 1978).

The Massachusetts statute challenged in this case gives the minor no quarter. Despite this Court's statement in *Danforth, supra,* that the mature minor has the right to make the abortion decision in consultation with her physician, the statute denies her that right and vests it instead in her parents and the court. Again, if the minor is immature, the statute forces her to involve her parents despite this Court's statement that in some cases a court should have the right to decide what is in her best interests "without parental consultation". In other words, the Massachusetts statute requires *parental involvement* in every case where a minor seeks an abortion regardless of the maturity of the minor and the nature and character of the parents (e.g., a father of a minor who himself caused the pregnancy). The statute as thus construed by the Supreme Judicial Court of Massachusetts, is, for these reasons, clearly unconstitutional.

POINT II

The Massachusetts statute is an unconstitutional violation of minors' rights to decide, with their physicians, to have an abortion.

This Court ruled in *Roe* v. *Wade* that "the abortion decision in all its aspects is inherently and primarily a medical decision and basic responsibility for it must rest with the physician". 410 U.S. at 166. The Massachusetts statute attempts to transfer that responsibility with respect to unmarried minors (regardless of their degree of maturity) to parents and courts, severely limiting the role and discretion of physicians. *Amici* believe that this is an unreasonable interference with the physician's professional judgment and discretion as well as the minor's right of privacy.

When parents are not supportive, the pregnant minor's counseling needs can best be met by sympathetic professionals:

> "The tendency of a minor's pregnancy to polarize the family automatically limits the ability of parents to counsel their children effectively. In many cases, the initial unwillingness of the minor to inform her parents of her pregnancy may indicate a fundamental conflict between the parents' and the child's views on sexual activity, pregnancy and abortion. In this context, parental advice cannot be expected to be dispassionate, supportive and effective."

Note, "The Minor's Right of Privacy: Limitations on State Action After *Danforth* and *Carey*", 77 Col. L. Rev. 1216, 1239 (1977); see also Shouse, "Psychological and Emotional Problems of Pregnancy in Teenage Adolescence", in Zackler and Brandtadt, eds., *The Teenage Pregnant Girl* (Thomas 1975), pp. 161-168.

The unreasonable and arbitrary character of the statute's requirement that parents be involved *in every case* in which a minor seeks an abortion is not affected by the Attorney General's quotation from Blackstone that Providence his implanted "in the heart of every parent that natural or insuperable degree of affection" which neither the individual parent's depravity nor rebellious children can totally extinguish. Appellants' Brief 30. That adage lacks force at a time when the Federal government estimates that one in every five children in the United States is abused. (N.Y. Times, Dec. 23, 1978, "New X-Ray System Can Detect Child Abuse Cases, Expert Says.") Nor is it reassuring to be told that a requirement of parental consultation is "beneficent both in social purpose and in the great majority of applications . . ." Appellants' Brief 31.

The law already assures that every pregnant girl will have the guidance of her physician in making the abortion decision. Obviously these physicians can and will encourage parental involvement in those cases where they believe it will be in the girl's best interests. If a state were concerned that the advice provided by physicians might be insufficient, it could require that the girl obtain additional consultation and advice from another supportive adult—either a parent, an approved counselor, or a mature person with a continuing supportive relation with the girl. This is emphatically not what Massachusetts has done. Rather, it demands parental consultation in every case, whatever the nature of the relationship between parent and child. The statute has no impact on those families in which there is already a relationship of communication and trust. It has no impact in those situations in which the minor will involve her parent because her physician has, on the basis of his or her best judgment, insisted that she do so. The statute impacts only in those situations in which neither the girl nor her physician would seek to involve the parents, except for the command of the state. When the relationship between parent and child is distant or destructive, or when the parent opposes abortion for reasons unrelated to the girl's best interests, the result is to force her to bear an unwanted child or to seek services outside the law.

Although the emotional support of understanding parents may well be desirable, few parents are in fact able to provide information which will actually bear upon the decision the minor may reach in consultation with a physician or other helping adults. Indeed, the evidence clearly suggests that there is a substantial correlation between parental ignorance or reluctance to discuss contraception and

a teenage daughter's subsequent misinformation and inability to approach her parents on such matters as unwanted teenage pregnancy. Baudry & Wiener, "The Pregnant Patient in Conflict About Abortion: A Challenge for the Obstetrician", 119 Am. J. Obst. & Gyn. 705 (1974); Zelnik and Kantner, "Sexual Contraceptive Experience of Young Unmarried Women in the United States: 1976 and 1971", 9 Family Planning Perspectives 55 (1977); Zelnik and Kantner, "First Pregnancies to Women Ages 15-19: 1976 and 1971", 10 Family Planning Perspectives 11 (1978); Zelnik and Kantner, "Contraceptive Patterns and Premarital Pregnancy Among Women Aged 15-19 in 1976", 10 Family Planning Perspectives 135 (1978).

As one commentator has noted:

> "Even if a minor is unable to understand fully the broad consequences of an abortion, parental input may do little to increase her comprehension. Certainly parents can seldom supplement the attending physician's explanation of the medical risks of abortion and may, in fact, seriously distort the dangers inherent in the procedure."

Note, "The Minor's Right of Privacy: Limitations on State Action After *Danforth* and *Carey*", 77 Col. L. Rev. 1216, 1238 (1977).

Not only may parents lack medical information but their advice may well be purely subjective and reflective of strong personal convictions of their own concerning abortion rather than any objective judgment as to the minor's best interests. This Court has recognized that a person's position on the abortion issue is affected by numerous considerations:

> "One's philosophy, one's experiences, one's exposure to the raw edges of human existence, one's religious training, one's attitudes toward life and family and their values, and the moral standards one establishes and seeks to observe, are all likely to influence and to color one's thinking and conclusion about abortion."
>
> *Roe* v. *Wade*, 410 U.S. 113, 116 (1973)

A requirement of parental involvement frequently creates nothing more than an emotionally charged forum for divergent views on the abortion issue, and is not likely to provide to the minor the guidance she needs in order to make a well reasoned decision.

> "Those who insist on parental consent are concerned less with the child's well being than with strengthening their general opposition to abortion, which they cloak in the magical notion that law can improve family communications by compelling a young women in trouble to consult with her parents when such family trust does not exist."

Goldstein, "Medical Care for the Child at Risk: On State Supervention of Parental Autonomy," 86 Yale L.J. 645, 662 (1977).

Physicians who specialize in adolescent health care have long recognized the importance of a confidential relationship between the doctor and his adolescent patient. Adolescents "have reached the stage of development where they can profit from, and they badly need, the benefits which a confidential relationship with a doctor of their own afford them". J. Roswell Gallagher, M.D., "The Care of Adolescents", in *Medical Care of the Adolescent* p. 64 (3d ed. Appleton-Century-Crofts, New York 1977). "More adolescents than ever are away from home, and there is a rising incidence of medical problems such as venereal disease, pregnancy, and drug abuse, often the result of behavior at odds with parental wishes. The doctor has come to stand square center in the debate when youths in these or similar circumstances seek confidential medical care on their own consent". Adele Hofmann, M.D., "Consent and Confidentiality and Their Legal and Ethical Implications for Adolescent Medicine", in *Medical Care of the Adolescent* p. 42 (3d ed. Appleton-Century-Crofts, New York 1977).

Physicians may be the only persons who can provide precisely the sort of patient understanding that the pregnant minor needs and may be unable to obtain at home. Dauber, *et al.*, "Abortion Counseling and Behavioral Change", 4 Family Planning Perspectives 23 (1972). The trained health professional is in an excellent position to perceive both the pregnant minor's needs for medical assistance and for counseling. Baudry & Wiener, "The Pregnant Patient in Conflict About Abortion: A Challenge for the Obstetrician", 119 Am. J. Obst. & Gyn. 705 (1974).

Some youngsters can be ably assisted by physicians and other health personnel to solicit and gain parental involvement. Others in the absence of parental support require help in identifying "significant others", be they responsible relatives, friends or social and welfare agencies to whom they can turn for the emotional support they need. (Moreover, to prevent a subsequent unwanted pregnancy, a teenager needs assistance in discovering the dynamic etiology of the preceding one, as well as advice on contraceptive methods. Tietze, "Repeat Abortions—Why More?" 10 Family Planning Perspectives 286 (1978).)

Appellants argue that unless parental consultation is mandated, many teenagers will not receive essential coun-

seling. But a requirement of parental consultation and consent is not the only way, and indeed is often not a good way to ensure that counseling is received. Other and better alternatives are usually available, such as state-approved counseling services or a requirement that clinics offering abortion services make counseling available.

> "This kind of State action largely avoids the constitutional deficiencies of parental consultation and notice provisions. It leaves the mature minor free to make fundamental decisions without parental or judicial interference while providing the less mature child with the type of support and counseling reasonably capable of alerting her to the general risks involved in such decisions."

Note, "The Minor's Right of Privacy: Limitations on State Action after *Danforth* and *Carey*", 77 Col. L. Rev. 1216, 1241 (1977).

Professional counseling services are important not only in making a decision about whether to terminate a pregnancy, but afterward as well, regardless of whether the teenager has an abortion or carries to term. "(C)onsiderably more emphasis has been given to the psychological effects of abortion than to the psychological effects of carrying through an out-of-wedlock pregnancy and either keeping the baby or giving it up for adoption . . . (M)any females . . . persist in mourning the child whom they have given up for adoption, wishing that they had kept the child and wondering what he or she is like". Osofsky and Osofsky, "Teenage Pregnancy: Psychosocial Considerations" in 21 Clinical Obstetrics and Gynecology, No. 4, p. 1166 (Harper & Row Medical Dep't, December 1978).

Studies have also documented the severe burden placed on adolescents who choose to keep their babies. Having responsibility for a child, frequently without the help of a husband or father, curtails the educational and occupational attainments of these young women and leads to a greater degree of welfare dependency and need for medical and other public assistance. Hardy, Welcher, Stanley & Dallas, "Long Range Outcome of Adolescent Pregnancy" in 21 Clinical Obstetrics & Gynecology, No. 4, p. 1230 (Harper & Row Medical Dep't, December 1978); Card and Wise, "Teenage Mothers and Teenage Fathers: The Impact of Early Childbearing on the Parents' Personal and Professional Lives," 10 Family Planning Perspectives 199 (1978). A recent study shows that in 1975, the government disbursed $9.4 billion to households through AFDC (Aid to Families with Dependent Children). Of this total, about half, $4.65 billion, was paid to households containing women who had borne their first child while still teenagers. Moore, "Teenage Childbirth and Welfare Dependency," 10 Family Planning Perspectives 233, 234 (1978).

All of these complex factors point to the need for professional guidance in this sensitive area. The approach of the Massachusetts statute is simplistic and overbroad, and would destroy for many young women the confidential relationship with physicians and other professionally trained counselors which they desperately need.

The appellants have cited the model statute governing the ability of minors to consent to health care adopted by the American Academy of Pediatrics. 51 Pediatrics 293, cited in Appellants' Brief at p. 16. It is noteworthy that the model act, which excludes abortion from its coverage, was published in February, 1973, and adopted before this Court invalidated the statutes then in effect in most states

which made many abortions criminal. In a subsequent report of the Committee on Youth of the American Academy of Pediatrics (chaired by Dr. Sprague Hazard, appellants' expert), that Committee recognized that "(c)ontacting the family in the absence of a youth's permission to do so may risk losing the patient to care and enhance the likelihood that he will not seek it under similar circumstances in the future. There may also be an effect on other youths in the community who will come to perceive that the promises of confidentiality are not inviolate". "The Implications of Minor's Consent Legislation for Adolescent Health Care: A Commentary", 54 Pediatrics 481 (October 1974). In its report (which was reviewed and approved by the Academy's Council on Child Health) the Committee on Youth said:

> "The adolescent needs to be provided certain medical care on his own consent, if this is the only manner under which he will accept it; but, it is of prime importance that a concerted, but noncoercive, effort be made to assist the still dependent and immature teenaged patient to ultimately agree to involve parents to obtain the benefit of their support and guidance. Minors' consent laws* not only provide for remediation of a medical need, but they also foster a situation wherein a concerned and caring professional may well serve as an intermediary in restoring interrupted intrafamily communication and unity, which could not have come about otherwise."

Although the American Academy of Pediatrics has not focused its attention on the specific issue of abortion since this Court in 1973 recognized it as a fundamental right,

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* Meaning laws that enable minors to consent for their own medical care.

other groups have done so. The American Academy of Child Psychiatry, composed of 2,000 child psychiatrists and the Society for Adolescent Medicine, have joined the other *amici* in filing this brief.

Attached as Appendix A is a position statement adopted by the American Academy of Child Psychiatry in October, 1977. The position statement, adopted in connection with the issue of Medicaid funding for abortion, sets forth the problems attendant upon adolescent pregnancy and childbearing and concludes that these problems tend to pass from generation to generation, perpetuating "a cycle of social and educational failure, mental and physical illness, and serious delinquency". The position statement asserts "that the freedom to act to interrupt this cycle must be considered a mental health imperative with major social implications".

POINT III

Since compliance with the statute will needlessly postpone the termination of many pregnancies, thus substantially increasing health hazards to the pregnant minor, the Massachusetts statute also violates the 14th Amendment on this ground.

Once a pregnant woman, in consultation with her physician, decides to terminate a pregnancy, it is essential that she obtain that operation as soon as possible. By delaying every pregnancy termination pending parental consent or judicial action, the Massachusetts statute increases the health risks a minor woman faces. Institute of Health, *Legalized Abortion and the Public Health* (Nat. Acad. Sci. 1975) 47-48.

The safest time to terminate a pregnancy is during the first trimester, preferably by the eighth week. "'The Earlier the Safer' Applies to All Abortions", 10 Family Planning Perspectives 243 (1978). The risks a woman desiring an abortion faces during this period, as during the entire duration of her pregnancy, are a function of her gestation period. The risks of an abortion procedure increase after the eighth week. Thus, the total morbidity* risk a woman faces increases from 4.55 per 100 abortions at the eighth week to 5.47 per 100 by the twelfth week. This means that each week a woman delays obtaining an abortion increases the risks she will face and that by the 12th week these risks will have risen by 20% beyond what they were at the eighth week. Cates, *et al.*, "The Effect of Delay and Method Choice on the Risk of Abortion Morbidity", 9 Family Planning Perspectives 266 (1977).

More important, however, is the major morbidity risk (i.e. the risk of major complication). While the major morbidity risk stands at .23 per 100 abortions at the eighth week of pregnancy, it has increased by 57% at the 10th week and by the 12th week is .44 per 100, representing an increase of 91%. Cates, *ibid.* The delay inherent in requiring a minor to comply with the Massachusetts statute, presumably predicated on a desire to improve the quality of the minor's decision will, especially when the minor comes from a hostile family situation, only increase the risk to which she will be exposed if she finally does obtain an abortion. Each additional condition imposed on the decision of a minor and her physician to terminate a pregnancy actually increases the health hazard the woman must face. *Wynn* v. *Carey,* No. 78-1262 (7th Cir. August 17, 1978) slip opinion pp. 22-23.

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* The term "total morbidity" denotes the possible complications, major and minor, attending an abortion.

The operation of the Massachusetts statute may push the actual termination of a pregnancy into the second trimester. The methods available after the first trimester—dilation and evacuation, saline instillation and prostaglandin instillation—are each significantly more hazardous than the method of suction and curettage available in the first trimester. By the time she reaches the 16th week of her pregnancy, the minor faces health risks from three to thirteen times as great as those she faced at the eighth week. Cates, *ibid.;* Grimes *et al.*, "Methods of Midtrimester Abortion: Which Is Safest?" 15 Int'l J. Gyn. & Obst. 184 (1977).

Despite the fact that by the second trimester the morbidity risk is quite high, it does not yet approach the risk a minor faces should she decide to carry the child to term. Cates and Tietze, "Standardized Mortality Rates Associated with Legal Abortion: United States 1972-1975", 10 Family Planning Perspectives 109 (1978).

Concern for the minor's well being is woefully inconsistent with a rule which in application can only further endanger her health. Forcing a woman to postpone a decision to terminate her pregnancy subjects her to unnecessarily increased medical risks and the costs associated with treating complications that do arise. Von Allmen, *et al.*, "Costs of Treating Abortion-related Complications," 9 Family Planning Perspectives 273 (1977). As one court put it:

> "The class of minor women plaintiffs seek to exercise a constitutional right which, with each passing day, becomes physically more difficult and dangerous, to the end that their constitutionally guaranteed decision to terminate their pregnancy may be totally frustrated

if they are prevented from acting with dispatch." *Wynn* v. *Scott,* 448 F. Supp. 997, 1004 (D. Ill. 1978), *aff'd, Wynn* v. *Carey,* No. 78-1262 (7th Cir. August 17, 1978).

While the Massachusetts Supreme Judicial Court has indicated that all such court proceedings will be handled expeditiously, *amici* submit that the statutory scheme is bound to cause harmful delays. Two factors are likely to lead to delay: the minor's reluctance to involve her parents from the outset and the passage of time inherent in judicial proceedings. As we have shown, fear of intra-familial strife will often delay a minor's decision to approach her parents with her problem and may in fact compel her to seek alternative, dangerous methods of coping with her unwanted pregnancy. It is already well established that a minor, because of her ignorance or embarrassment about her possible pregnancy or even because of her refusal to acknowledge such a possibility, will almost invariably delay seeking medical assistance until relatively late in the gestation period. In fact, only about 30% of pregnant minors seek aid before the eighth week and the majority wait until the 10th week or even later. Fielding *et al.,* "Comparison of Women Seeking Early and Late Abortion", 131 Am. J. Obst. & Gyn. 304 (1978); Bracken and Kasl, "Psychosocial Correlates of Delayed Decisions to Abort", 4 Health Ed. Monographs 1 (1976).

While the teenager's unfamiliarity with her own reproductive cycle contributes to her failure to recognize and act on her pregnancy (Mallory, *et al.,* "Factors Responsible for Delay in Obtaining Interruption of Pregnancy", 40 Obst. & Gyn. 556 (1972)), she will also be influenced by attitudes she encounters among friends, relatives and her

family. All these factors contribute to her psychological trauma in such a way that she is unable to perceive the dimensions of her problem and the need to seek out immediate medical assistance. Bracken and Swigar, "Factors Associated with Delay in Seeking Abortion", 113 Am. J. Obst. & Gyn. 301 (1972). As a result of her failure to obtain timely medical assistance, the pregnant teenager exposes herself to a greater risk of complication if she decides to have an abortion. By avoiding or delaying her decision to obtain such assistance, she may also lose the opportunity to obtain the early prenatal care which is invaluable to her own health and to the health of her child should she carry the pregnancy to term. Berger, "Abortions in America: The Effects of Restrictive Funding", 298 N. Eng. J. Med. 1474 (1978).

The structure and organization of the Massachusetts court system and the procedures suggested by the state court are bound to cause further delay. There is no statutory provision for expediting such proceedings or for ensuring that any appellate review will be handled quickly. Once provision is made for advance parental notification, appointment of counsel for the minor (if the judge deems it necessary), a hearing, a decision and an appeal, the minor may be well beyond a point in time when abortion is a possible course of action.

The final and most cruel irony of the statute, as interpreted by the Massachusetts court, is that the judge could very well decide that, even though the minor is sufficiently mature to give informed consent, the delays caused by the court procedure itself have themselves made the desired abortion not in the minor's best interests.

Even if this does not happen, however, a typical proceeding (given the minor's probable lack of counsel or of pro-

cedural expertise) may easily consume a week or two, substantially increasing the health hazards of abortion. *Amici* submit that this is an "undue burden", seriously interfering with the doctor-patient relationship, and that it is not justified by any "significant state interest" because the adversary proceeding is unlikely to improve either the quality of the minor's decision or her relationship with her family.

POINT IV

The Massachusetts statute denies the equal protection of the laws to those minors who choose to terminate their pregnancies as opposed to those minors who choose to carry their pregnancies to term.

Massachusetts has no law requiring parental consent or even parental consultation for medical services for a minor who chooses to carry her pregnancy to term. Indeed Massachusetts law gives mature minors the right to consent for medical services in general, and a 1975 Massachusetts statute enables any minor (mature or not) who is pregnant or believes herself to be pregnant to give consent to medical care without any parental involvement at all. Mass. Gen. Laws ch. 112, § 12F, as added by Mass. Stat. 1975, ch. 564. That statute excludes only abortion and sterilization (which is not involved in this case and which differs significantly from other medical procedures because it is intended to and usually does cut off permanently the patient's ability to have children).

It appears to be generally conceded and indeed it has been held that a parent may not force a minor child to have an abortion. *In re Smith*, 16 Md. App. 209, 295 A. 2d 23 (1972). By the same token, it is inconsistent with any

right of privacy a minor may have for a parent or parents to have a right to compel their minor child to have a child she does not want and for whom she probably cannot provide the care and nurture that an infant requires. This Court has, of course, held in *Danforth* and in *Carey* v. *Population Services International*, 431 U.S. 678 (1977), that minors do have a constitutional right of privacy in connection with childbearing. The Massachusetts statute demands parental consent or notification for abortion and not for the decision to carry a pregnancy to term notwithstanding the fact that childbirth, especially for minors, is many times more dangerous in terms of morbidity and mortality than abortion.

The evidence before the Court in *Roe* v. *Wade* was that "[m]ortality rates for women undergoing early abortions, where the procedure is legal, appear to be as low as or lower than the rates for normal childbirth." 410 U.S. 113, 149. During the 1970's maternal mortality rates have decreased, and as legal abortions have been more widely available the risks of abortion have decreased dramatically. The situation is now one in which for white women the risk of death from childbirth (9.5 per 100,000) is almost *twenty times* as great as the risk of death from legal abortion (0.5 per 100,000). For black women the risk of death from childbirth is 3½ times that for white women (32.7 per 100,000); it is also over thirteen times as great as their fivefold risk of death from legal abortion (2.4 per 100,000). Cates *et al.*, *Legal Abortion: Are American Black Women Healthier Because of It?*, DHEW, Pub. Health Serv., CDC, 1976. See also Petitti *et al.*, *Restricting Medicaid Funds for Abortions: Projections of Excess Mortality for Women of Childbearing Age*, DHEW, CDC, 1977, pp. 3-4.

As dramatic as these figures are, they understate the extent to which teenagers are injured when the state creates obstacles which prevent them from obtaining abortions which they seek. The comparisons assume that minors who are unable to obtain legal abortions will continue their pregnancies rather than seek illegal or self abortions which threaten substantially greater risks to their life and health. The comparisons are based on mortality rates for all childbirth, wanted and unwanted. Where pregnancy is unsought and unwanted, it creates significantly greater risks to the women. Finally the comparative figures are surely understated because they include all women, while the women affected by the Massachusetts law are teenagers. The risks of childbirth are significantly greater for teenagers than for adults,* but there is no evidence that the risks of abortion are any greater for teenagers than for other women.

Surely, if parental involvement is not required before a minor can obtain medical services in the more hazardous situation of carrying a pregnancy to term, it cannot be required for the less hazardous procedure of abortion. The State has suggested no reason why pregnant minors are less capable of deciding whether to terminate their pregnancy than they are to decide whether to carry their pregnancy to term, or even to have a Caesarian section, a far more dangerous procedure than a first trimester abor-

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* Teenagers are significantly more likely to suffer the ultimate biological risk—death—than older pregnant women. Fatal complications late in pregnancy are 60% more likely for a girl under 15 than for a woman 20-24 and 13% more likely between the ages of 15 and 19. Alan Guttmacher Institute, *11 Million Teenagers*, 1976, pp. 22-23. 1974 vital statistics show that girls 15-19 years old are twice as likely to suffer fatal complications as the result of hemorrhage, spontaneous abortion or toxemia as women 20-24. Under 15 they are 3.5 times more likely to die of toxemia. *Id.* at pp. 21, 62.

(footnote continued on following page)

tion. *Wynn* v. *Carey*, No. 78-1262 (7th Cir. August 17, 1978) slip opinion p. 20. The failure to require parental consent for carying a pregnancy to term underlies the unreasonableness of requiring such consent to terminate that pregnancy.

This Court's decisions in *Maher* v. *Roe*, 432 U.S. 464 (1977) and *Beal* v. *Doe*, 432 U.S. 438 (1977) are not to the contrary. Those cases held that the state may by public funding "favor childbirth over abortion". Such funding, this Court said in *Maher*, "places no obstacles—absolute or otherwise—in the pregnant woman's path to an abortion". This Court further pointed out that "Constitutional concerns are greatest when the State attempts to impose its will by force of law; the State's power to encourage actions deemed to be in the public interest is necessarily far broader". *Maher* v. *Roe*, 432 U.S. at 476.

Massachusetts Gen. Laws ch. 112, § 12 S makes it a criminal offense to perform an abortion upon a minor without parental consent or notification although a physician is specifically authorized by Massachusetts law to render medical services without parental consent or notification to a pregnant minor who chooses to carry her pregnancy to term. For this further reason, the Massachusetts statute must fall.

The risks of severe, but not-fatal complications of pregnancy, many of which permanently impair the young woman's future life, health and reproductive capacity, are also significantly higher for teenagers. DHEW reports that "studies show pregnant adolescents have higher rates of toxemia, prolonged labor, premature delivery, pelvic disproportion and Caesarean section than more mature women." D-HEW, *Approaches to Adolescent Health Care*, 1975, p. 17. Girls continue growing for an average of five years after the onset of menses, which, in the United States, occurs at an average age of 12.8. D-HEW, Office of Child Health Affairs, *Teenage Pregnancy*, 1976, p. 5. Teenage pregnancy appears to stop the crucial process of physical growth although this impact is at present "poorly understood." *Ibid.*

CONCLUSION

For the reasons stated in this brief and in the briefs of the appellees, *amici* respectfully urge that this Court affirm the judgment of the three-judge court below.*

Respectfully submitted,

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APPENDIX A

TWENTY FOURTH ANNUAL MEETING OCTOBER 19-23, 1977
AMERICAN ACADEMY OF CHILD PSYCHIATRY
SUITE 904, 1800 R STREET, N.W.
WASHINGTON, D.C. 20009
(202) 462-3754

HOUSTON, TEXAS, OCTOBER, 1977

The American Academy of Child Psychiatry is aware of the national debate concerning the funding of abortion by the Medicaid system. The Academy wishes to declare that there is now a body of scientific data which confirms:

1) that the young adolescent most vulnerable to early pregnancy is the product of adverse sociocultural conditions involving poverty, discrimination, family disorganization and the like,

2) that the resulting pregnancy is statistically laden with medical complications that threaten the well being of both mother and fetus,

3) that the delivery that ensues is prone to prematurity and major threats to the health of both mother and child,

4) that the resulting newborns have a higher percentage of birth defects, developmental difficulties and a poorer life and health expectancy than the average for our society,

5) that such children are often not given up for adoption and eventually get caught in the web of the foster care and welfare systems where they enter a lifetime of dependency and expensive social interventions,

6) that these children are often unwanted and in a short time become prone to abuse, neglect, failure to thrive, and serious medical illness,

7) that the tendency of this pattern to pass from generation to generation is very marked and thus serves to perpetuate a cycle of social and educational failure, mental and physical illness, and serious delinquency and

8) that the freedom to act to interrupt this cycle must be considered a mental health imperative with major social implications.

As a result of these data, it is urgently recommended that elective abortion for teenage pregnancy be adequately funded within the Medicaid System.